

Foundations: Provider Program Basics

NEVADA MEDICAID AND NEVADA CHECK UP

Updated April 2014



Topics


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About Nevada Medicaid

- Nevada Medicaid is a program that provides quality health care services to low-income Nevadans who qualify based on federal and state law. Nevada Medicaid does not reimburse an individual; rather, payments are sent directly to the health care providers for services provided to Medicaid recipients.
- Nevada Check Up is a program designed for children who do not qualify for Medicaid, but whose incomes are at or below 200% of the Federal Poverty Level (FPL). Participants in the Nevada Check Up program are charged a quarterly premium based on family size income.

<https://dhcfp.nv.gov/index.htm>



Nevada Department of Health and Human Services

Division of Health Care Financing and Policy



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Division of Health Care Financing and Policy (DHCFP)

The Division of Health Care Financing and Policy (DHCFP) works in partnership with the [Centers for Medicare & Medicaid Services](#) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources. The medical programs are known as Medicaid and Nevada Check Up.

Medicaid

Provides health care coverage for many people including low income families with children whose family income is at or below 133% percent of poverty, Supplemental Security Income (SSI) recipients, certain Medicare beneficiaries, and recipients of adoption assistance, foster care and some children aging out of foster care. The DHCFP also operates five Home or Community-Based Services waivers offered to certain persons throughout the state. The Division of Welfare and Supportive Services (DWSS) determines eligibility for the Medicaid program. Information regarding eligibility is available on line at <https://dwss.nv.gov/> or by calling toll free at 1-800-992-0900.

Nevada Check Up

Provides health care benefits to uninsured children from low-income families who are not eligible for Medicaid but whose family income is at or below 200% of the Federal Poverty Level. Information regarding the Nevada Check Up program is available at www.nevadacheckup.nv.gov or by calling toll free at 1-877-543-7669.

Services for both Medicaid and Nevada Check Up are provided through a combination of traditional fee-for-service provider networks and managed care.

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[Apply for Medical Assistance Programs](#)

[Report Medicaid Fraud!](#)

☐ The Web ☒ DHCFP

WHAT'S NEW

IMPORTANT!

[Changes to State of Nevada Banking Services](#)

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Roles and Responsibilities

Division of Welfare and Supportive Services (DWSS)

- Accepts Applications for Medicaid Assistance (not Nevada Check Up)
- Determines eligibility
- Creates and updates recipient case files

Division of Health Care Financing and Policy (DHCFP)

- Establishes policies and exceptions to policy for administration of the Medicaid programs
- Determines eligibility for Nevada Check Up and advises recipients in all aspects of Nevada Check Up coverage

HP Enterprise Services (HPES)

- Fiscal agent
- Receives and processes claims
- Customer Service Center
- Provides training to providers
- Prior authorization
- Follows policy and guidelines in Medicaid Services Manual (MSM)



Roles and Responsibilities

Medicaid Providers

- Verify eligibility prior to rendering services
- Submit claims on paper or electronically, timely, completely and accurately
- Pursue third party payment resources before billing Medicaid
- Stay alert to changes in Billing Guides and Forms for specialty
- Follow policy and guidelines in the MSM




Recipients


- Advise caseworker of third-party coverage
- Present their Medicaid card when services are rendered
- Prevent anyone else from using their Medicaid card
- Keep or cancel appointments with providers

Web Portal



Provider Web Portal – www.medicaid.nv.gov

**Nevada Department of Health and Human Services**
Division of Health Care Financing and Policy Provider Portal



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Latest News

January, February and March 2014 Provider Training Reminder [[Web Announcement 679](#)]

Attention Pharmacies: Claims adjudication process to validate ordering, prescribing and referring (OPR) practitioners [[Web Announcement 702](#)]

Nevada Medicaid and Nevada Check Up News (Fourth Quarter 2013 Provider Newsletter) [[Read](#)]

Provider Web Portal Quick Reference Guide (Updated April 16, 2012) [[Review](#)]

[Web Announcements](#) [View All](#)

WEB ANNOUNCEMENT 705

[Policy for Habilitation Services for EPSDT](#)

Habilitation services are provided in order for a person to attain, maintain or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

Medically necessary therapy services (Occupational, Physical and Speech/Communication) provided by provider types 12 (Hospitals, Outpatient), 60 (School Based Services) and 34 (Therapy) under the EPSDT program include habilitation services for individuals under the age of 21.

WEB ANNOUNCEMENT 704

[Claim Form Instructions Online for New CMS-1500 \(02-12\) and 2012 ADA Claim Forms](#)

Claim form instructions for the new CMS-1500 (02-12) and 2012 American Dental Association (ADA) claim forms are now available on this website on the [Provider Billing Information](#) webpage. Please review the instructions and the field requirements.


Nevada Medicaid began accepting the CMS-1500 (02-12) claim form and the 2012 ADA claim form on January 2, 2014. A three-month dual-use period of the CMS-1500 (version 08/05) and the 2006 ADA forms and the new forms is in effect through March 31, 2014. **Claims received by HP Enterprise Services on or after April 1, 2014, must be on the new CMS-1500 (02-12) and 2012 ADA claim forms.** Effective April 1, 2014, the CMS-1500 (version 08/05) and the 2006 ADA will be returned to providers.

“Providers” Tab – Sub Menu




Access important documentation through the “Providers” tab, such as Billing Information, EDI, Enrollment and Provider Training

Announcements & Newsletters



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Notification
 Enhancements were implemented in the online prior authorization and electronic verification systems on February 20, 2012. For more information, see [Web Announcement 451](#).

Announcements & Newsletters



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Date	Newsletter/Announcement Number	Topic
March 18, 2013	Announcement 579	Healthy Kids (EPSDT)/Well Baby/Well Child Screening Forms Now Available Online
March 15, 2013	Announcement 578	March Provider Training Reminder
March 11, 2013	Announcement 577	Dental Providers (PT 22): Client Treatment History and Handicapping Labiolingual Deviation Forms
March 8, 2013	Announcement 576	Use Email to Submit Your Enrollment Application
March 7, 2013	Announcement 575	FAQs Regarding Recent Recoupments on Obstetrical Services Provided to Undocumented Citizens
March 7, 2013	Announcement 574	Attention Provider Types 12 and 17: Prior Authorization Required for Therapy Services
Feb. 28, 2013	Announcement 573	Provider Type 39 (ADHC): Use HCPCS Code S5102 for All-day Services
Feb. 28, 2013	Announcement 572	Base Rate Set for CPT Code 80055 (Obstetric Panel)
Feb. 27, 2013	Announcement 571	Changes to DHCFP Banking Services
Feb. 27, 2013	Announcement 570	Attention Provider Types 11 and 19: Room and Board Claims to be Reprocessed
Feb. 25, 2013	Announcement 569	Reminder to Provider Type 22 (Dental): Dental History Request Form
Feb. 20, 2013	Announcement 568	Dental Providers: Clarification of Daily Service Limits for CDT Codes D0210, D0220 and D0230
Feb. 15, 2013	Announcement 567	2013 CPT, HCPCS and CDT Codes (Updated February 25, 2013)
Feb. 15, 2013	Announcement 566	Enhancements to Online Prior Authorization Search Options
Feb. 13, 2013	Announcement 565	Instructions for the Use of Modifiers 25 and EP with Vaccine and Vaccine Administration Codes
Feb. 12, 2013	Announcement 564	Attention Provider Types 25 and 41: Some Claims for Ocular Lenses and Ocular Services Reprocessed
Feb. 8, 2013	Announcement 563	URGENT Update for PTs 20, 24 and 74: Regarding Resubmitting Claims for Obstetrical Deliveries for Medicaid Recipients with Emergency Service Only Eligibility
Jan. 23, 2013	Announcement 562	URGENT Notice for PTs 20 and 74: Regarding Recoupments for Global OB Services Rendered to Nevada Medicaid Recipients with Emergency Service Only Eligibility
Jan. 23, 2013	Announcement 561	Concerta® Announcement for Provider Types 14, 17, 20, 21, 22, 24, 25, 27, 28, 31, 36, 37, 45, 72, 76
Jan. 21, 2013	Announcement 560	Provider Types 12 and 27 to be Paid Technical Component Rate for Radiology Codes
Jan. 21, 2013	Announcement 559	EVS User Manual Updated
Jan. 21, 2013	Announcement 558	Do Not Use Modifier TC on Surgical Pathological Consultation Codes

Billing Information



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Wednesday 04/02/2014 03:27 PM P


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Billing Information

FAQs: National Correct Coding Initiative (NCCI) Claim Review Edits [[Review Now](#)]




Clinical Claim Editor FAQs Updated December 5, 2011 [[Review Now](#)]




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Paper Claim Form Instructions




The following instructions are for paper claims. For electronic claim requirements, technical professionals can refer to Companion Guides for transactions [837D](#), [837I](#) and [837P](#).

Title	Last Update
 ADA (Version 2012) Claim Form Instructions	02/11/14
 ADA (Version 2006) Claim Form Instructions	12/05/11
 CMS-1500 (02-12) Claim Form Instructions	02/10/14
 CMS-1500 (08/05) Claim Form Instructions	05/14/13
 UB Claim Form Instructions	05/14/13

Billing Manual
 For Archives [Click here](#)


Title	Filesize	Last Update
 Billing Manual	977 KB	12/05/11

Billing Guidelines (by Provider Type)
 For Archives [Click here](#)

Provider Type	Title	Last Update
10	 Outpatient Surgery, Hospital Based	02/01/12
11	 Hospital, Inpatient	11/08/13
12	 Hospital, Outpatient	07/11/12
13	 Psychiatric Hospital, Inpatient	02/01/12
14	 Behavioral Health Outpatient Treatment	07/09/13

Electronic Claims/EDI

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Notification
Enhancements were implemented in the online prior authorization and electronic verification systems on February 20, 2012. For more information, see [Web Announcement 451](#).

Electronic Claims / EDI

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Electronic billing (also called Electronic Data Interchange or "EDI") speeds payment and eliminates costs associated with paper claims. You can submit electronic claims through a clearinghouse or through your existing, HIPAA-compliant business management software.

If you have any questions, please contact our EDI Coordinator at:

Telephone: (877) 638-3472
Fax: (775) 784-7932

EDI ENROLLMENT FORMS

EDI enrollment forms are for completion and submission by active or enrolling Nevada Medicaid and Nevada Check Up providers only.

Form Number	Title
FA-35	Electronic Transaction Agreement for Service Centers
FA-36	Service Center Operational Information
FA-37	Service Center Authorization
FA-39	Payerpath Enrollment

Form Number	Title
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EDI ANNOUNCEMENTS

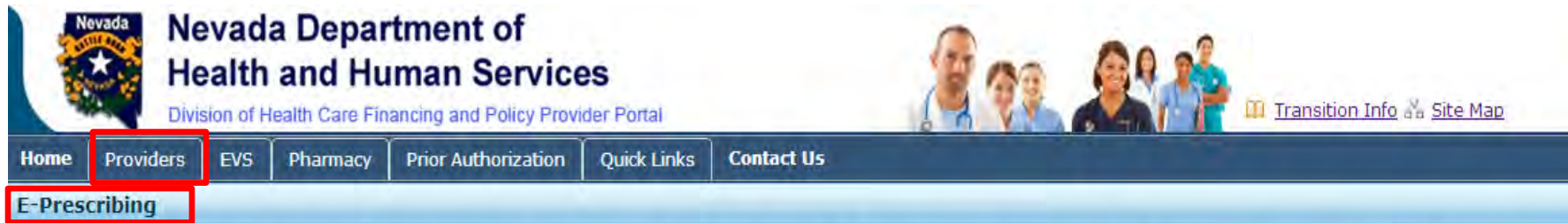
Title	Date
EDI Announcement: Dual Use for 4010/5010 Formats Ends June 30, 2012	June 5, 2012
Anesthesia Services Claims Submitted Electronically (Updated May 31, 2012)	May 4, 2012
EDI Announcement: Nevada Medicaid Version 5010 Solution Limits Diagnosis Codes on 837P Transactions	Apr. 30, 2012
EDI Announcement: Prepare for March 31, 2012, End Date for Dual Use of 5010 and 00 Formats	Jan. 25, 2012
Instructions for EDI Enrollment	December 2011

Title	Date
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PAYERPATH

Enrolled providers may submit electronic Nevada Medicaid and Nevada Check Up claims free of charge through [Allscripts-Payerpath](#).

E-Prescribing



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E-Prescribing

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Nevada Medicaid/Nevada Check Up Fee For Service providers may save valuable time, build staff efficiency and enhance the safety of the prescribing process by establishing an electronic prescribing connection with pharmacies. Electronic prescribing, also referred to as e-prescribing, is the exchange of prescription information through computer-to-computer connections, instead of issuing prescriptions by paper, fax or phone. The computer-to-computer process is safer and more secure for recipients, prescribers and pharmacies, because paper faxes are eliminated.

An additional money-saving benefit for providers who use e-prescribing is that they are exempt from the tamper-resistant prescription pad requirements in effect for all written, non-electronic prescriptions for Medicaid Fee For Service outpatient drugs.

Nevada Medicaid/Nevada Check Up providers who use electronic prescribing now have access to data that will assist them in managing prescriptions for recipients more efficiently. Information the Division of Health Care Financing and Policy (DHCFP) and HP Enterprise Services have made available through prescribers' practice management software vendors includes:

- Recipient pharmacy claims history
- Eligibility data
- Indication of the need for prior authorization

The recipient data provided by DHCFP and HP Enterprise Services to software vendors is transmitted via technologies that are compliant with Health Insurance Portability and Accountability Act (HIPAA) security requirements.


Contact your practice management software vendor to enable your system for Nevada Medicaid/Nevada Check Up e-prescriptions. The functionality of your system is determined by your software vendor.

The following websites offer detailed information and assistance to prescribers and pharmacies:

Forms



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Forms




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Prior Authorization Forms

All prior authorization forms are for completion and submission by current Medicaid providers only.

Form Number	Title
FA-1	Durable Medical Equipment Prior Authorization Request
FA-1A	Usage Evaluation for Continuing Use of BIPAP and CPAP Devices
FA-1B	Mobility Assessment and Prior Authorization (PA), Revised 12/29/10
FA-1B Instructions	Mobility Assessment and Prior Authorization (PA) Instructions
FA-3	Inpatient Rehabilitation Referral/Assignment
FA-4	Long Term Acute Care Prior Authorization
FA-6	Outpatient Medical/Surgical Services Prior Authorization Request
FA-7	Outpatient Rehabilitation and Therapy Services Prior Authorization Request
FA-8	Inpatient Medical/Surgical Prior Authorization Request
FA-8A	Induction of Labor Prior to 39 Weeks and Scheduled Elective C-Sections
FA-10A	Psychological Testing
FA-10B	Neuropsychological Testing
FA-10C	Developmental Testing
FA-10D	Neurobehavioral Status Exam
FA-11	Outpatient Mental Health Request
FA-11A	Behavioral Health Authorization
FA-11C	Crisis Intervention Services
FA-12	Inpatient Mental Health Prior Authorization
FA-13	Residential Treatment Center Concurrent Review
FA-13A	RTC Therapeutic Home Pass Form
FA-14	Inpatient Mental Health Services Concurrent Review Request

National Drug Code (NDC)

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National Drug Code (NDC)



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NDC Resources for Nevada Medicaid and Nevada Check Up Providers

- [Billing Reference](#)
- [CMS Drug Product Data](#)
- [Frequently Asked Questions – Updated January 27, 2011](#)
- [NDC Billing Reference for Physician Administered Drugs \(NVPAD\) Claims](#)

Provider Enrollment

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Provider Enrollment							

New Requirements for Provider Re-enrollment

Beginning June 1, 2012, providers are required to re-enroll in Nevada Medicaid and Nevada Check Up once every 36 months. Providers who do not re-enroll within 60 days of the date on their notification will have their provider contract terminated. Please see [Web Announcement 510](#).



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Thank you for your interest in the Nevada Medicaid and Nevada Check Up Program. This page contains all of the information and forms you will need to become a Nevada Medicaid provider. If you have any questions, please contact the Provider Enrollment Unit at (877) 638-3472 from 8a.m. to 5p.m. Monday through Friday.

All enrollment documents including attachments require an *original* signature from the provider or an authorized representative (use dark blue or black ink).

Changes to Provider Information

Changes to any information presented on your enrollment documents must be reported to HP Enterprise Services within five business days.

- To report a change in business ownership, resubmit a completed Provider Enrollment Application.
- For all other changes, the [Provider Information Change Form \(FA-33\)](#) may be used.

Mailing Address

Mail completed enrollment forms and required documentation to HP Enterprise Services, Provider Enrollment Unit, P.O. Box 30042, Reno, NV 89520-3042

Required Enrollment Documents

- [Provider Enrollment Information Booklet](#): All providers will need the information contained in this booklet, which includes common enrollment questions and information about out-of-state providers and provider groups.
- [Enrollment Checklists](#): Copies of certain documents must be included with your Provider Enrollment Packet (e.g., copy of professional certification, proof of insurance, background check). The Enrollment Checklists show required documentation for each provider type.
- [Business Associate Addendum \(NMH-3820\)](#): This document must be signed and submitted with your Provider Enrollment/Re-Enrollment Packet if it is listed on the Provider Enrollment Checklist for your Provider Type and when requested by the Division of Health Care Financing and Policy (DHCFP) or HP Enterprise Services (HPES).

Initial Enrollment Documents

- [Provider Initial Enrollment Application Packet \(Individuals\) \(FA-31C\)](#): Complete and submit the forms in this packet if you are enrolling as a Nevada Medicaid and Nevada Check Up individual provider. This packet contains instructions, application and contract.
- [Provider Initial Enrollment Application Packet \(Groups\) \(FA-31D\)](#): Complete and submit the forms in this packet if you are enrolling as a Nevada Medicaid and Nevada Check Up group/facility provider. This packet contains instructions, application and contract.

Re-Enrollment Documents

- [Provider Re-Enrollment Application Packet \(Individuals\) \(FA-31A\)](#): The forms in this packet must be submitted by active individual providers who have received a re-enrollment



Provider Training

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Provider Training

Provider Training Catalog

HP Enterprise Services offers comprehensive provider training free of charge. We encourage the attendance of health care providers, direct practitioners, billing staff, billing agencies, office managers, admitting or front-desk staff, utilization review staff, case management staff, etc.



Title
 2014 Provider Training Catalog
Title

Registration

Registration is required for all classes and workshops. Due to limited space, you are encouraged to register early; registration closes when a class or workshop reaches maximum capacity.

Classes and workshops are free to providers and staff.

Advanced classes, taken in conjunction with new provider training classes are recommended for all new Medicaid providers/staff, and as a yearly review for established providers/staff.

Form Number	Title
FA-41	 2014 Training Registration Form
FA-43	 Pharmacy Provider Training Registration
Form Number	Title


Computer Based Training

Self-paced training course available on demand for providers.

Updated Date	Topic
Aug. 24, 2012	CMS 1500 Form – Basic Introduction (This course is being updated. Please check back.)
Updated Date	Topic

Workshop Materials

Workshop materials will be posted to this site upon completion of the workshop.

Date	Topic
March 2014	 Quarterly Provider Training

Eligibility



Who Is Eligible For Nevada Medicaid?

- Low-income eligibility
 - Children
 - Pregnant women
 - Families with dependent children
 - Disabled adults
 - Persons age 65 or older
 - Childless adults (expanded January 2014)
- Other
 - Caregivers (kinship, foster care)
 - Katie Beckett



Who Is Eligible For Nevada Check Up?

- Must be 18 years of age or younger
- Eligibility based on:
 - Total gross income of household members
 - Citizenship/legal residency status
 - Health insurance status
- Persons who are eligible for Nevada Medicaid cannot be eligible for Nevada Check Up



Why verify eligibility?

- Ensure recipient has active benefits
- Allows you to check for other coverage (Third Party Liability)
- Send claim to the right place the first time
- Reduces claim denials

Welfare office



<https://dwss.nv.gov>

The Nevada Department of Health and Human Services offers medical assistance through a number of programs for individuals and families. The services provided may include doctor visits, prescriptions, dental care, eye exams and glasses, and therapies to name a few.

Recipients receive some services for free and some for a small fee.

Eligibility can be Verified in Three Ways:

1. Automated Response System (ARS):
(800) 942-6511
2. Electronic Verification System (EVS) through
www.medicaid.nv.gov
3. Swipe Card system



Using the ARS

ARS is:

- The acronym for Automated Response System
- The automated phone access to recipient eligibility, provider payments, claim status and prior authorization status
- Accessed at (800) 942-6511



ARS

You will be asked for the following information:

- **NPI or API**
 - After you enter this info, it will repeat it back to you, press 1 if correct or press 2 to make changes
- **Select from one of the following options:**
 - For Enrollee Eligibility Verification, press 1
 - For Recent Check Amounts, press 2
 - For Claim Status, press 3
 - For Prior Authorization Status, press 4
 - To Return to the Main Menu, press *

ARS – Enrollee Eligibility Verification

- Press 1 for Enrollee Eligibility Verification, and then enter the following information:
 - Enter 11-digit enrollee ID number or the 9-digit Social Security Number
 - Enter the 8-digit “from” date of service (MM/DD/YEAR format)
 - Enter the 8-digit “through” date of service if different, otherwise press #

NOTE: You can return to the Main Menu at any time by pressing the star key (*)

ARS – Recent Check Amounts

- Press 2 for Recent Check Amounts:
 - The automated response system will return the most current payment information, including the payment date and EFT or check number
 - Press 1 for the next most current payment information
 - Press 1 for the next most current payment information

TIP: ARS gives 3 weeks worth of current payment information

ARS – Claim Status

- Press 3 for Claim Status, and then enter the following information:
 - 11-digit enrollee ID #
 - 8-digit “from” date of service (MM/DD/YEAR)
 - 8-digit “to” date of service (MM/DD/YEAR) if it differs from date of service, otherwise press #

TIP: You will then need to press a certain number depending on the claim type you are searching for. See the next slide for the numbers to press.

ARS – Claim Status – Continued

- Press 0 for Inpatient
- Press 1 for Long Term Care (LTC)
- Press 2 for Outpatient/Home Health
- Press 3 for Personal Care
- Press 4 for Practitioner
- Press 5 for Pharmacy
- Press 6 for Independent Lab
- Press 7 for Medicare Crossover
- Press 8 for Dental
- Press 9 for Transportation

ARS – Prior Authorization Status

- Press 4 for Prior Authorization Status and enter the following information:
 - 11-digit enrollee ID #
 - 8-digit “from” date of service (MM/DD/YEAR), this is the begin date of your authorization
 - 11-digit prior authorization number if known, otherwise press #

TIP: ARS will give you the PA information, including the PA number and the status (Certified, Not Certified, etc.)

ARS – May We Suggest You Write It Down

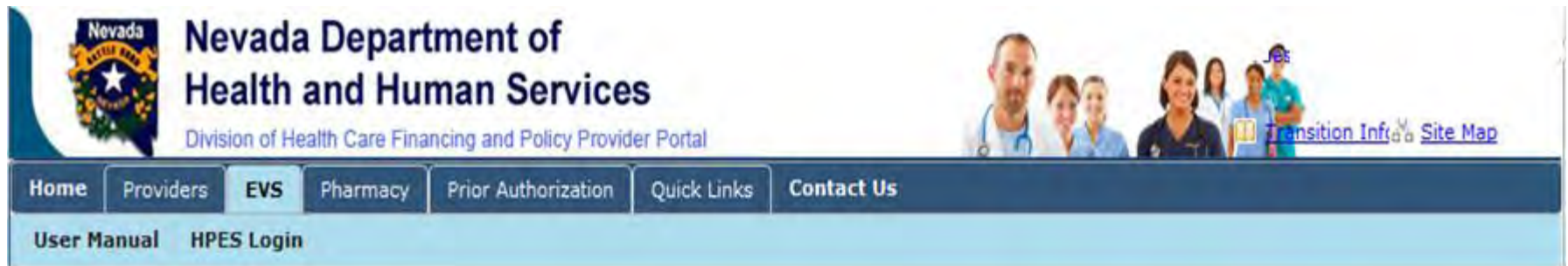
- Be sure to have paper and pencil handy when receiving your automated information
- Listen through the entire recording, because important information is given up to the end of the message
- Know that the private insurance information is given to you in carrier codes and not by name
- You can verify more than one recipient ID per phone call

Navigating EVS





Electronic Verification System (EVS)

- Providers must register through EVS for access to: eligibility, payment history, claim status, remittance advices (RAs) and prior authorization
- Click on “User Manual” for instructions
- Click on “HPES Login” to login into the system
- For EVS support, call (877) 638-3472; use option 2, option 0, then option 6 for Web Support



EVS – User Manual

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Division of Health Care Financing and Policy Provider Portal




Wednesday 04/02/2014 03:35 PM PST

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[User Manual](#) **[HPES Login](#)**

EVS User Manual

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The HP Enterprise Services HIPAA-compliant Electronic Verification System (EVS) provides Internet access to:


- Recipient eligibility
- The status of submitted claims
- Prior authorization requests and inquiries, including pharmacy prior authorizations
- Provider payment amounts and remittance advice (RA) access

Title
 Chapter 1: Getting Started
 Chapter 2: Eligibility Benefit Verification
 Chapter 3: Claim Status Verification
 Chapter 4: Prior Authorization
 Chapter 5: Provider Payment History and RA Access

Title

EVS – Login Page

**Nevada Department of Health and Human Services**
Division of Health Care Financing and Policy Provider Portal



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Tuesday 03/19/2013 10:18 AM PST

Provider Login ?

***User ID**

Log In

[Forgot User ID?](#)

[Register Now](#)


[Where do I enter my password?](#)

Protect Your Privacy!
Always log off and close all of your browser windows

Broadcast Messages

Hours of Availability
The Nevada Provider Web Portal is unavailable between midnight and 12:25 AM PST Monday-Saturday and between 8 PM and 12:25 AM PST on Sunday.

What can you do in the Provider Portal
Through this secure and easy to use internet portal, healthcare providers can inquire on the status of their claims and payments, inquire on a patient's eligibility, process prior authorization requests and access Remittance Advices. In addition, healthcare providers can use this site for further access to contact information for services provided under the Nevada Medicaid program.




Website Requirements
New! Prior Authorization Quick Reference Guide [\[Review\]](#)
Provider Web Portal Quick Reference Guide [\[Review\]](#)


EVS – Provider Services

[My Home](#) [Eligibility](#) [Claims](#) [Care Management](#) [Resources](#) [Switch Provider](#)


My Home

 **Provider**


Welcome
Name
Provider ID
Location ID
Enrollment Period

Enrollment Status  **ACTIVE**
PENDING
RE-ENROLLMENT

[My Profile](#)
[Switch Provider](#)


 **Provider Services**

[Member Focused Viewing](#)
[Search Payment History](#)
[PASRR](#)
[EHR Incentive Program](#)
[EPSDT](#)
[Affiliated Provider Enrollments](#)

 **Broadcast Messages**


Hours of Availability
The Nevada Provider Web Portal is unavailable between midnight and 12:25 AM PST Monday-Saturday and between 8 PM and 12:25 AM PST on Sunday.


Welcome Health Care Professional!



We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and search for claims, payment information, and access Remittance Advices. Our secure site provides access to eligibility, answers to frequently asked questions, and the ability to process authorizations.

New! Prior Authorization Quick Reference Guide [\[Review\]](#)



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All Claim Inquiries should be submitted to the following Address:

Nevada Medicaid Administration
P.O.Box 30042
Reno, NV 89520-3042

36 Foundations: Provider Program Basics



EVS – Eligibility

**Nevada Department of Health and Human Services**
Division of Health Care Financing and Policy Provider Portal

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[My Home](#) > Member Focus Search

Member Focus Search ?

Last Members Viewed

The most recent members you viewed are listed below. Click on the member name below to access the Member Focus View.

Recipient ID	Recipient	Gender	Birth Date	City	ZIP Code
00000123456	JANE DOE	Female	08/31/1959	LAS VEGAS	89101-0000

Member Focus View



Nevada Department of Health and Human Services

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[My Home](#) > [Member Focus Search](#) > Member Focus View

Member in Focus:

[Close Member Focus](#)



Member Details

Recipient ID
Name
Birth Date
City
State
Gender
Primary Language

Coverage Details

Coverage	Effective Date	End Date
MEDICAID FFS		

▶ [View eligibility verification information](#)

Other Details



[Secure Correspondence](#)

Review previously sent messages or send new secure messages.

Your Member Claims


Medical/Dental

There are no claims for this member.

Your Member Authorizations


▶ [Submit an Authorization](#)

Member Focus Search – Eligibility



Nevada Department of Health and Human Services

Division of Health Care Financing and Policy Provider Portal



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Claims

Care Management

Resources

[My Home](#) > Member Focus Search

Tuesday 11/08/2011 06:43 PM PST

Member Focus Search

Last Members Viewed

Search

* Indicates a required field.

Please enter the member ID or last name and at least one other field, then click Search.


Recipient ID

Last Name

City

First Name

Birth Date



ZIP Code

Search

Reset

Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes, descriptions and data are copyrighted by the American Medical Association (AMA) and the American Dental Association (ADA), respectively, all rights reserved. AMA and ADA assume no liability for data contained or not contained on this website and on



Search Payment History



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My Home

Tuesday 09/06/2011 10:33 AM PST

**Provider**

Name

Provider ID

Location ID

▶ [My Profile](#)

▶ [Manage Account](#)

**Provider Services**

▶ [Member Focused Viewing](#)

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▶ [PASRR](#)

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All Claim Inquiries should be submitted to the following Address:

Nevada Medicaid Administration
P.O.Box 30042
Reno, NV 89520-3042

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

Search Payment History Tab

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[Search Claims](#) [Search Payment History](#)

[Claims](#) > Search Payment History

Delegate for	Role IDs	Location
--------------	----------	----------

Search Payment History ?

Provider Information











Provider ID	ID Type	NPI	Name
	Location ID	003	

* Indicates a required field.

Payment Method	All	Payment Type	All	Check # / RA #	
Issue Date	* From	12/19/2012	* To	03/19/2013	

[Search](#) [Reset](#)

Remittance Advice (RA)

<div> <div>Search</div> <div>Reset</div> </div>					
Search Results					
<p>To see payment details, click on the payment ID link.</p> <p>To access a copy of the Remittance Advice, select the 'RA' icon. Access to the RA will require PDF software.</p> <p>RA's are not available if the payment was for Pharmacy Claims.</p> <p>If the RA is too large to display, the icon will be disabled. You will need to contact Customer Service for assistance.</p>					
Issue Date	Payment Method	Payment Type	Payment ID	Total Paid Amount	RA Copy (PDF)
08/26/2011	EFT	-			
08/26/2011	EFT	-			
08/26/2011	EFT	-			
08/05/2011	EFT	-			 View Remittance A
08/05/2011	EFT	-			
08/05/2011	EFT	-			
08/05/2011	EFT	-			
07/29/2011	EFT	-			
07/29/2011	EFT	-			
07/29/2011	EFT	-			
					1 2 ...


This page allows you to view several RA's at a time.

- The payment ID is your RA number

- Total amt = what was paid on that RA

- RA Copy = Print for the Medicaid RA. It is different from the electronic RA's and gives you the Nevada Medicaid codes and explanations

Search Claims

**Nevada Department of Health and Human Services**
Division of Health Care Financing and Policy Provider Portal

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[Search Claims](#) [Search Payment History](#)

[Claims](#) > Search Claims

Delegate for	Role IDs	Location
--------------	----------	----------

Search Claims ?

Medical/Dental

A minimum one field is required.
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.
Claim searches are limited to a maximum range of 45 days.


Claim Information



Claim ID

Member Information

Recipient ID


Service Information


Rendering Provider ID  ID Type Claim Type

Service From  To  Claim Status

EVS Eligibility

Eligibility

**Nevada Department of Health and Human Services**
Division of Health Care Financing and Policy Provider Portal



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Eligibility

Delegate for

Role IDs

Location

Eligibility Verification Request ?

* Indicates a required field.
Enter the recipient information. If Recipient ID is not known, enter SSN and Birth Date. Please verify response below as not all information is currently used during search.

Recipient ID

SSN*

Effective From

03/19/2013

Last Name

Birth Date*


Effective To*

First Name

Submit

Reset

Eligibility Verification

**Nevada Department of Health and Human Services**
Division of Health Care Financing and Policy Provider Portal

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[My Home](#) **Eligibility** [Claims](#) [Care Management](#) [Resources](#) [Switch Provider](#)

Eligibility

Delegate for	Role IDs	Location
--------------	----------	----------

Eligibility Verification Request ?

* Indicates a required field.
Enter the recipient information. If Recipient ID is not known, enter SSN and Birth Date. Please verify response below as not all information is currently used during search.

Recipient ID	Last Name	First Name
SSN	Birth Date	
* Effective From	Effective To	

Submit **Reset**

Eligibility Verification Information for DEYON M WILLIAMS from 03/01/2013 to 03/01/2013

Recipient ID	Birth Date	09/29/1967	
Coverage	Effective Date	End Date	Primary Care Provider
MEDICAID FFS			0000000000

[Other Insurance Detail Information](#)

Eligibility – Medicaid FFS Only

Eligibility Verification Information for			
Recipient ID		Birth Date	
Coverage	Effective Date	End Date	Primary Care Provider
MEDICAID FFS			0000000000
Other Insurance Detail Information			

Other Insurance Information for DEYON M WILLIAMS		Back to Eligibility Verification Request ?
There is no information available for the Other Insurance. Contact Us for more information.		

- Under this coverage, the detail may display MEDICAID FFS. This verifies that the recipient is eligible to receive Nevada Medicaid benefits.
- There is no other TPL on file.
- Provider has 180 days from the Date of Service (DOS) or the Date of Decision (DOD) to submit a clean and correct claim for reimbursement.

Medicaid FFS and MCO

Eligibility Verification Information for				Shows the name of the MCO.
Recipient ID	Birth Date			
Coverage	Effective Date	End Date	Primary Provider	
MEDICAID FFS			0000000000	
XIX MAN NNEV			HEALTH PLAN OF NEVADA, INC (9005039928)	
Other Insurance Detail Information				

- This eligibility shows the recipient has Medicaid medical benefits and is enrolled with a Medicaid Managed Care Organization (MCO).
- You must be contracted with this Medicaid MCO in order to provide services that can be reimbursed.
- Check the “Other Insurance Detail Information” for any other payers before submitting a claim to Medicaid.

Expanded view of MCO

Verification
number

Verification Response ID 11745-0000021

Benefit Details

Coverage	Description	Date of Decision
MEDICAID FFS	Medicaid Fee For Service (Patient Pay : 0.00)	06/03/2011
XIX MAN NNEV	Medicaid Mandatory MCO North	06/03/2011

Managed Care Assignment Details

Date of Decision

Managed Care Assignment Details

Primary Care Provider	Type	Provider Phone	Benefit Plan
HEALTH PLAN OF NEVADA, INC	Health Benefit Plan Coverage	1-702-838-2077	XIX MAN NNEV
Current MCO			NPI/API
HEALTH PLAN OF NEVADA, INC			9005039928

Bill your claims to this
MCO provider

Medicaid FFS / Med Co & Ded

Eligibility Verification Information for [REDACTED]

Recipient ID	Birth Date		
Coverage	Effective Date	End Date	Primary Care Provider
MEDICAID FFS			0000000000
MED CO & DED			0000000000
Other Insurance Detail Information			

Coverage Details for from to		Back to Eligibility Verification Request ?
Verification Response ID 11684-0000011		Expand All Collapse All
Benefit Details		In this example, the recipient is eligible for full Medicaid benefits as well as Medicare coinsurance and deductible payable up to the Medicaid maximum allowable amount.
Coverage	Description	
MEDICAID FFS	Medicaid Fee For Service	
MED CO & DED	Medicare Coinsurance and Deductible	

Other Insurance Details – Continued

Other Insurance Information for MARGARET FEISTER						Back to Eligibility Verification Request ?		
Carrier	Policy ID	Group ID	Policy Holder	Policy Type	Coverage Type	Primary	Effective Date	End Date
MEDICARE OPS CTR PART A	318305853A	-		-	30 (Non Specific)	Yes	05/01/1986	12/31/9999
MEDICARE OPS CTR PART B		-		-	30 (Non Specific)	Yes	05/01/1986	12/31/9999
MEDICARE OPS CTR PART D		-		-	30 (Non Specific)	Yes	01/01/2006	12/31/9999
TEAMSTERS BENEFIT TRUST		-		-	55 (Major Medical)	Yes	01/01/2000	12/31/9999
TEAMSTERS BENEFIT TRUST		-		-	AL (Vision (Optometry))	Yes	01/01/2000	12/31/9999
TEAMSTERS BENEFIT TRUST		-		-	35 (Dental Care)	Yes	01/01/2000	12/31/9999
TRIWEST		-		-	55 (Major Medical)	Yes	09/12/2002	12/31/9999
TRIWEST		-		-	A4 (Psychiatric)	Yes	09/12/2002	12/31/9999
EXPRESS SCRIPTS		-		-	88 (Pharmacy)	Yes	11/04/2009	12/31/9999

Med Co and Deductible Only

Recipient ID		Birth Date	
Coverage	Effective Date	End Date	Primary Care Provider
MED CO & DED			0000000000

Verification Response ID

Benefit Details			
Coverage	Description	Date of Decision	
MED CO & DED	Medicare Coinsurance and Deductible	02/11/2010	

- Medicaid pays only the deductibles and co-insurance for Qualified Medicare Beneficiary (QMB) recipients up to Medicaid allowable amounts.
- If Medicare does not cover the code, neither will Medicaid. Be sure to check other insurance details.

Nursing Facility

Coverage	Effective Date	End Date	Primary Care Provider
MEDICAID FFS			0000000000
XIX NF			-----

Benefit Details		
Coverage	Description	Date of Decision
MEDICAID FFS	Medicaid Fee For Service	07/02/2011
XIX NF	Medicaid Nursing Facility Resident	07/02/2011

Intermediate Care Facility for the Mentally Retarded (ICF/MR)

Coverage	Effective Date	End Date	Primary Care Provider
MEDICAID FFS			0000000000
XIX ICF/MR			

[Other Insurance Detail Information](#)

Verification Response ID

Benefit Details			-
Coverage	Description	Date of Decision	
MEDICAID FFS	Medicaid Fee For Service (Patient Pay : 0.00)	09/08/2004	
XIX ICF/MR	Medicaid Intermediate Care Facility for Mentally Retarded Resident	09/08/2004	

Managed Care Assignment Details

+

Pregnancy Benefit

Eligibility Verification Information for			
Recipient ID		Birth Date	
Coverage	Effective Date	End Date	Primary Care Provider
MEDICAID FFS			0000000000
XIX PRGNANCY			0000000000
Other Insurance Detail Information			

Benefit Details		
Coverage	Description	Date of Decision
MEDICAID FFS	Medicaid Fee For Service	03/09/2011
XIX PRGNANCY	Medicaid Pregnancy Related Services	03/09/2011

Aged Waiver Program

Eligibility Verification Information for			
Recipient ID	Birth Date		
Coverage	Effective Date	End Date	Primary Care Provider
MEDICAID FFS			0000000000
AGED HOME WV			0000000000
Other Insurance Detail Information			

[Expand All](#) | [Collapse All](#)

Verification Response ID 11731-0000020

Benefit Details		
Coverage	Description	Date of Decision
MEDICAID FFS	Medicaid Fee For Service (Patient Pay : 0.00)	03/07/2009
AGED HOME WV	Medicaid Aged Waiver - Home Based Senior (Frail Elderly)	03/07/2009

Emergency Benefit

Eligibility Verification Information for			
Recipient		Birth Date	
Coverage	Effective Date	End Date	Primary Care Provider
MEDICAID FFS			0000000000
XIX EMERGENCY			0000000000
Other Insurance Detail Information			

Emergency services are defined as a case in which delay in treatment of more than 24 hours could result in severe pain, loss of life, limb, eyesight or hearing, injury to self or bodily harm to others (MSM 203.4A.2)

Verification Response ID

Benefit Details			
Coverage	Description	Date of Decision	
MEDICAID FFS	Medicaid Fee For Service (Patient Pay : 0.00)	11/09/2011	
XIX EMERGENCY	Medicaid Emergency Services	11/09/2011	

Medicaid benefits – page 1

The table below show abbreviations used in the EVS Coverage field and the full name of the corresponding coverage plan. For information on which services are covered under a specific plan, please contact your local Medicaid District Office.

EVS Abbreviation	Coverage Full Name
XXI CMM PHAR	Check-Up CMM Lock-In Pharmacy
XXI CMM PHYS	Check-Up CMM Lock-In Physician
XXI CMM TRAN	Check-Up CMM Lock-In Transportation
XXI MAN DFLT	Check-Up Default MCO
XXI VOL DFLT	Check-Up Default Primary Care Case Management (PCCM)
CHECK-UP FFS	Check-Up Fee For Service
XXI HOSP R&B	Check-Up Hospice Room and Board – Nursing Facility
XXI HOSP SVC	Check-Up Hospice Services
XXI ICF/MR	Check-Up Intermediate Care Facility for Mentally Retarded Resident
XXI BECKETT	Check-Up Katie Beckett
XXI MAN NNEV	Check-Up Mandatory MCO North
XXI MAN SNEV	Check-Up Mandatory MCO South
XXI NF	Check-Up Nursing Facility Resident
XXI RTC	Check-Up Residential Treatment Center (RTC) Resident
AGED GRP WVS	Medicaid Aged Waiver – Elderly in Adult Residential Care
AGED HOME WV	Medicaid Aged Waiver - Home Based Senior (Frail Elderly)
ASST LVG WVR	Medicaid Assisted Living Waiver
XIX CMM PHAR	Medicaid CMM Lock-In Pharmacy
XIX CMM PHYS	Medicaid CMM Lock-In Physician
XIX CMM TRAN	Medicaid CMM Lock-In Transportation
XIX MAN DFLT	Medicaid Default MCO
XIX VOL DFLT	Medicaid Default Primary Case Care Management (PCCM)
XIX EMERGENCY	Medicaid Emergency Services
MEDICAID FFS	Medicaid Fee For Service
XIX HIPP	Medicaid HIPP Premium Payments

Medicaid benefits – page 2

EVS Abbreviation	Coverage Full Name
XIX HOSP R&B	Medicaid Hospice Room and Board – Nursing Facility
XIX HOSP SVC	Medicaid Hospice Services
XIX ICF/MR	Medicaid Intermediate Care Facility for Mentally Retarded Resident
XIX BECKETT	Medicaid Katie Beckett
XIX MAN NNEV	Medicaid Mandatory MCO North
XIX MAN SNEV	Medicaid Mandatory MCO South
MR WAIVER	Medicaid Mentally Retarded (MR) Waiver
XIX NF	Medicaid Nursing Facility Resident
DISABLED WVS	Medicaid Physically Disabled Waiver
XIX PRGNANCY	Medicaid Pregnancy Related Services
XIX RTC	Medicaid Residential Treatment Center (RTC) Resident
TICKET WORK	Medicaid Ticket to Work
NOMATCH FFS	No match Fee For Service
NOMATCH HIP	No match HIP Premium Payments
NMTCH ICF/	MR No match Intermediate Care Facility for the Mentally Retarded Resident
NOMATCH NF	No match Nursing Facility Resident
NOMATCH RTC	No match Residential Treatment Center (RTC) Resident
MED PREMIUM	Full Medicare Premiums
PRT MED PREM	Partial Medicare Premiums
MED CO & DED	Medicare Coinsurance and Deductible

- Individuals eligible for Medicare may also qualify for benefits from the Medicare Beneficiaries program. Coverage provided by this program is different from other Medicaid groups as it does not provide the full scope of medical benefits.
- **Qualified Medicare Beneficiaries (QMBs)** are Medicare recipients with income at or below 100% of the federal poverty level. Medicaid pays for their Medicare premiums, co-insurance and deductibles on Medicare covered services. Eligibility begins the month following the month the decision is made.

Med premium

MED PREMIUM	Full Medicare Premiums
PRT MED PREM	Partial Medicare Premiums

No Medicaid Benefits

The recipient is responsible for payment.

When just the MED PREMIUM or the PRT MED PREMIUM coverage plan is listed, Medicaid contributes to the member's Medicare premium only.

The member is not eligible for other benefits.

Managed Care Organizations (MCO)

Contracted Managed Care Organizations (MCO)



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Nevada - one state, endless opportunities. From multi-million-dollar resorts and desert landscapes to mountain vistas and quiet neighborhoods, Nevada has it all. New communities seem to spring up overnight as people from every state in the union relocate here to pursue the American dream.

As the state's oldest and most experienced health plan, we've provided Nevadans with quality health care since 1982. The reason for our success? We understand your unique goals and offer health plans to fit your individual lifestyle. After all, *good health takes a good plan.*

HPN@YourService
We're at Your Service

HPN

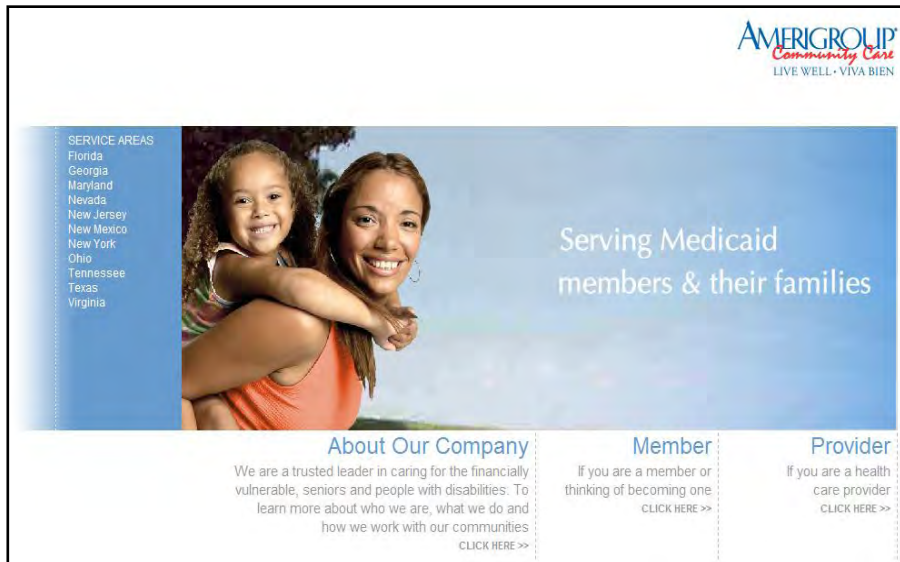
P.O. Box 15645

Las Vegas, NV 89114-5645

(702) 242-7317 or

(800) 962-8074

<http://www.healthplanofnevada.com>



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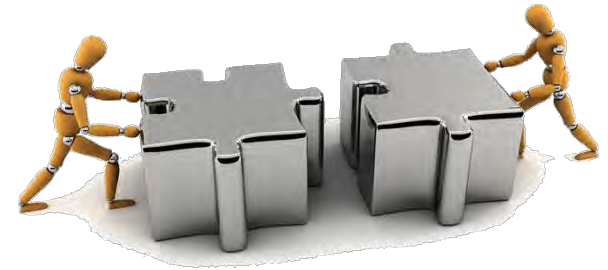
Managed Care Organizations (MCOs)

- The State of Nevada Managed Care Program requires the mandatory enrollment in an MCO of some recipients found eligible for Medicaid or Nevada Check Up.
- An MCO is responsible for reimbursing claims of eligible enrollees for services covered under the contract or for services the MCO has prior authorized for each month a capitated payment is made.



MCO enrollment

- Most urban Washoe and Clark county recipients
- In most cases, MCO enrollment begins the first of the month AFTER the date of assignment
- If the mother is in an MCO, the newborn is automatically enrolled in the same MCO as the mother
- Recipients have 30 days to choose an MCO before one is assigned to them
- There is open enrollment annually when managed care recipients can change MCOs



MCOs – The Provider's Responsibilities

- Follow MCO policy and procedure
- Submit claims to MCO
- Medicaid Services Manual (MSM) Chapter 3600
- Contract with MCO (terms determine payment)
- Contact DHCFP for MCO assistance for issues unresolved by MCO's grievance and appeals process



Remember...



- If a recipient has an MCO plan and you are not contracted with that MCO, refer the recipient to the MCO and instruct them to ask for assistance in finding an in-network provider who is currently accepting new patients.

Third Party Liability

Payer of Last Resort

Medicaid is *usually* the payer of last resort. The following programs are exceptions:



Report Incorrect TPL



Invalid TPL
information

Invalid Medicare
information




NOTE: Do not send claims to Emdeon or DHCFP

Third Party Liability records

TPL or Third Party Liability insurance providers carry some of the expense for recipients. Always check for a TPL provider.

- Private Insurance

-  Emdeon is the company that partners with HPES to perform Third Party Liability (TPL) identification and recovery.
- If you believe a recipient's private insurance records are incorrect, please contact Emdeon at:
 - Phone: (855) 528-2596
 - Email: TPL-NV@emdeon.com

Third Party Liability records – continued

Medicare

- If you believe a recipient's Medicare record is incorrect, please contact the DHCFP at:
 - Email: tpl@dhcftp.nv.gov



Contact Us



HPES Contact Information

HPES

Customer Service Center

Claim inquiries and general information

P.O. Box 30042

Reno, NV 89520-3042

Phone: (877) 638-3472 (select option 2, then select option 0, then select option 2 for "Claim Status")

www.medicaid.nv.gov

Nevada Provider Training

P.O. Box 30042

Reno NV 89520-3042

Phone: (877) 638-3472 (select option 2, then select option 0, then select option 4 for "Provider Training")

Fax: (775) 624-5979

Email: NevadaProviderTraining@hp.com



Provider Services Field Representatives

The HPES provider field representatives support provider education and outreach for the Nevada Medicaid provider community.

They provide training on subjects including:

- Claims billing (paper and electronic)
- Program policies and procedures
- Website tools

They resolve claim inquiries when providers are not able to obtain the claim information requested using the web portal, ARS or by calling the Customer Service Call Center.

They review remittance advice and reconciliation issues.

Contact Us

Providers may contact their assigned field representative by telephone and email (NevadaProviderTraining@hp.com) with inquiries.

- On-site visits at your Nevada professional place of business and virtual room sessions can also be scheduled by contacting your field representative.
- Requests for on-site visits should be made at least two weeks in advance.
- Please allow a minimum of 48 hours for telephone calls and emails to be returned.
- In addition, the Customer Service Center and scheduled training courses remain available to you and your staff members.

Provider Services Field Representatives May Be Contacted:

- By email – nevadaprovidertraining@hp.com
- By fax – (775) 624-5979



Questions?



Thank you for your attention

